

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 173

CERTIFICATE OF DEATH

#56

07862

Reg. Dist. No. 1

1. PLACE OF DEATH:

County

City or town

Gardner's
Grovewood Island

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Jerome S. Antel

4. Sex

M

5. Color or race

Married

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Miriam R. Antel

6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.)

August 12/1893

8. AGE: Years Months Days If less than one day

53 1

hrs. min.

9. Birthplace

Cleveland, Ohio

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

William Antel

12. Name

William Antel

13. Birthplace

Austria

14. Maiden name

Sarah Strauss

15. Birthplace

Germany

16. Informant

Myron Antel

Address

2625 Euclid Hghts Blvd

17. Burial

Cleveland, Ohio

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or cremator

Washington Hebrew Congregation

Location

Anacostia, D.C.

18. Funeral director

Danzeski

Address

14th St. S.E. N.W. St. C.

19. Date rec'd by registrar

8/14/46

19. Date rec'd by registrar

46

19. Date rec'd by registrar

New Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Washington, D.C.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

3629 Genes St. N.W.

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-13

1946

at

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19 to 19

and that I last saw h. alive on

19

Immediate cause of death

Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

accident

Date of 8-13-46

Where did injury occur? Downs (City or town)

Blair (County)

Md. (State)

Injured at home, farm, industry, public place (where?)

Means of injury Fell overboard Injured at work? No.

23. SIGNATURE

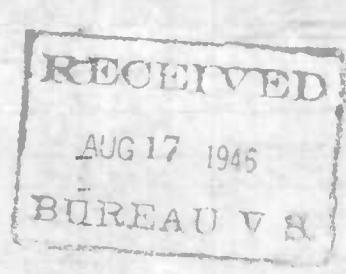
Dwight, M.D.

M. D. or other

Address

Dwight, M.D.

Date signed 8-18-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 166

CERTIFICATE OF DEATH

60
07863
51

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Calvert

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Leonard Coates Jr

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

M C S

6. (b) Name of husband or wife.....

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Sept 20, 1922

8. AGE: Years

Months

Days

If less than one day

23 24

11

2

hrs.

min.

9. Birthplace.....

Md

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business.....

Leonard Coates

FATHER

12. Name.....

Leonard Coates

MOTHER

13. Birthplace.....

Md

14. Maiden name.....

Blanche Rawlings

15. Birthplace.....

Md

16. Informant.....

Leonard Coates, Jr.

Address.....

Sunderland, Md

17. Burial

Date thereof.....

8-20-46
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Mt. Hope

Location.....

Calvert Co. Md

18. Funeral director.....

P. E. Service

Address.....

Prince Frederick, Md

19. 8-19

19. 46

(Date rec'd by registrar)

H. W. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Prince

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

World War II

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

8/18

19. 46

A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw him alive on.....

Immediate cause of death.....

Inflammation of the lungs

from pneumonia

caused by

19.....

19.....

19.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Howard Date of 8/18/46

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

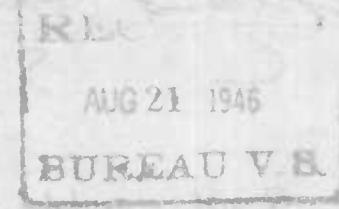
Means of injury.....

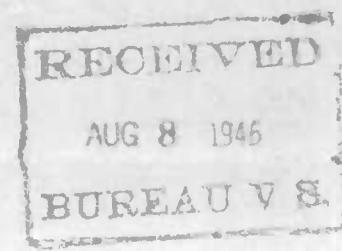
Injured at work?

23. SIGNATURE

H. Ward M. D. or other

Address..... Date signed 8/18/46





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

59

CERTIFICATE OF DEATH

07865

Reg. Dlat. No.

1. PLACE OF DEATH: *Calvert*
County.....City or town..... *Sunderland*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or Institution?.....

3. (a) FULL NAME
*David Horner*4. Sex *m* 5. Color or race *c.* 6.(a) Single, married, widowed, or divorced *x*

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *June 1854* 6.(c) If alive, give age years8. AGE: Years *95* Months Days If less than one day hrs. min. 9. Birthplace *md.* (Town, county, and state) *Farmers.*10. Usual occupation *Farmers.*11. Industry or business *Farmer*FATHER 12. Name *Samuel Horner*13. Birthplace *md*MOTHER 14. Maiden name *?*

15. Birthplace

16. Informant *Elsie Smith.*Address *Sunderland, md.* Date thereof *8-19-46*
(month) (day) (year)17. Burial Cemetery or crematory *Oliver Point* Date thereof *8-19-46*
(Burial, cremation, or removal, Which?)Location *Calvert.*18. Funeral director *P. F. Scargill*Address *Prince Frederick, Md.*19. Aug 17 1946 *H. W. Ward*
(Date rec'd by registrar) Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State *MD* County *Calvert*City or town..... *Sunderland*
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *8-16-46* 1946, at *11 AM*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *19* to *19*and that I last saw him alive on *19*Immediate cause of death *Accidens.*Due to *- Heart failure -*Due to *Hypertension & S. D.*Other conditions *Chronic nephritis*

(Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

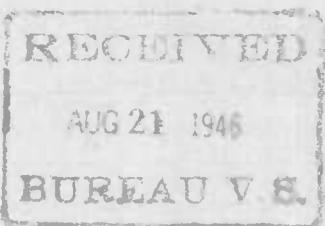
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *John Ward* M. D. or otherAddress *Prince Frederick* Date signed *Aug 17/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

07866

51

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Carroll

City or town

Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Carroll County Hospital

How long in hospital or institution?

3 days

3. (a) FULL NAME

S. Lawrence Scott

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Fannie Scott

7. Birth date of deceased (mo., day, yr.)

Feb. 27, 1875

6. (c) If alive, give age 68 years

8. AGE:

Years Months Days If less than one day

71

5

4

hrs.

min.

9. Birthplace

Carroll County, Md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Siflow Scott

MOTHER FATHER

12. Name

Carroll, Md

13. Birthplace

Annie R. Bowen

MOTHER

14. Maiden name

Carroll Co., Md

15. Birthplace

Fannie Scott

FATHER

16. Informant

Fannie Scott

Address

Martinsburg

Cemetery or crematory

Walter's Memorial

Location

Island Creek, Md

18. Funeral director

A. A. Harkness & Son

Address

Martinsburg, Md

19. Date rec'd by registrar

Aug 3 1946

X New Ward

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Carroll

City or town

Martinsburg

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

WW

3. (b) Social Security Number

220

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 1, 1946, at 6:1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h . . . alive on 19.

Immediate cause of death

Acute Cardiac Failure

DURATION

Due to

Hypertrophic

Cardiac Failure

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

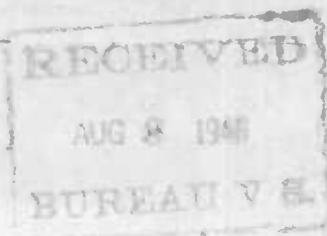
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

B. Lawrence Scott M. D. or other

Address Service Hospital Date signed 8/4/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52a

07868

22

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:

County

Calvert

City or town

Chesapeake Beach Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Lifetime

Hospital, institution, or street address where death occurred:

Her Home, Chesapeake Beach Md.

How long in hospital or institution?

3 months

3. (a) FULL NAME

Bertha Elizabeth Klein Gibson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

White married

6. (b) Name of husband or wife

Joseph Thomas Gibson

7. Birth date of

deceased (mo., day, yr.)

Feb. 22 1918

6. (c) If alive, give age 28 years

8. AGE:

Years

28

Months

5

Days

17

If less than one day

hrs.

min.

9. Birthplace

Chesapeake Beach (Calvert Co.) Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

George Klein

13. Birthplace

Philadelphia, PA.

14. Maiden name

Manise Phillips Klein

15. Birthplace

Maryland

16. Informant

Mrs. Bertha Gibson

Address

Baltimore, Maryland.

17. Burial

Burial

Date thereof Aug 11 46
(month) (day) (year)

Cemetery or crematory

Mt. Harmony C.

Location

Mr. Owens, Md.

18. Funeral director

W. N. Hutchins

Address

Owings, Md.

19. Date rec'd by registrar

Aug 9 10 1946 Grace L. Hutchins

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Calvert

City or town

Chesapeake Beach Md.

Street No.

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946 at 6:03 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 8 1946 to death 1946

and that I last saw her alive on Aug. 8 1946

Immediate cause of death

circulatory failure

Due to Metastatic Sarcoma 3 mon.

Due to Primary sarcoma of the kidney

cure

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Sarcoma in multiple metastatic lesions Date of op. May 17 46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

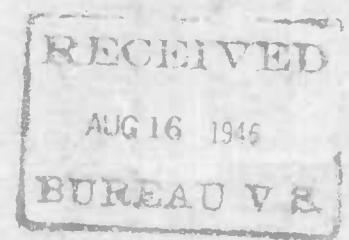
Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed Aug 9, 1946



Evidence for the additions made is
shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

07867

#64

FILE No. 108 OCT 29 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Avis Gwynne Avis Gwynne

4. Sex

7

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Feb. 19, 1890

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

56

6

5

hrs.

min.

9. Birthplace

Vid

(Town, county and state)

10. Usual occupation

Domestic

11. Industry or business

Aerodare Mfg

12. Name

Aerodare Mfg

13. Birthplace

Vid

14. Maiden name

Amanda Pyle

15. Birthplace

Vid

16. Informant

James Gwynne

Address

Clinton, V.I.

17. Burial

Date thereof

8-24-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Date thereof

Cemetery or crematory

St. Barnabas

Location

Oxon Hill, Md

18. Funeral director

Murray & Son

Address

Anacostia, D.C.

19. Date rec'd by registrar

8-24-46

Date rec'd by registrar

H. W. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Clinton

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

8/24

1946, at 1040 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

and that I last saw him alive on

19...

Immediate cause of death

Cerebral hemorrhage

DURATION

5 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Auto

Injured at work?

23. SIGNATURE

H. W. Ward

M. or other

Address

(If rural, give LOCATION)

Date signed

8/24/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1572

CERTIFICATE OF DEATH

62
07869 51
Reg. Dist. No.1. PLACE OF DEATH: *Calvert*
County *Parran* MarylandCity or town *Parran* Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? - *18 months*

Hospital, institution, or street address where death occurred:

How long in hospital or institution? *not*

3. (a) FULL NAME

*Douglas Harold*4. Sex *m.* 5. Color or race *c.* 6. (a) Single, married, widowed, or divorced *s.*6. (b) Name of husband or wife: *-*7. Birth date of deceased (mo., day, yr.) *Sept. 2, 1945* 6. (c) If alive, give age *years*8. AGE: Years *11* Months *22* Days *-* If less than one day *hrs. min.*9. Birthplace *PARRAN, Md*
(Town, county, and state)10. Usual occupation: *-*11. Industry or business: *-*12. Name *George Harold*
MOTHER FATHER13. Birthplace *Parran, Md.*14. Maiden name *Geneva Green*15. Birthplace *Plum Point, Md.*16. Informant *Mother: Geneva Harold*Address *Parran, Md.*17. Burial *Burial* Date thereof *8-25-46*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Plum Point*Location *Parran*18. Funeral director *P. E. Sewell*Address *Prince Frederick and*19. *8-24-1946* *N. Ward M.D.*
(Date rec'd by registrar) Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State *Maryland* County *Calvert*City or town *Parran, Md.*
(If outside city or town limits, write RURAL and give nearest town)Street No. *Parran, Md.*
(If rural, give LOCATION)2.(a) If veteran, name war: *-*

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 24 1946* at *6 AM*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *19* to *19*and that I last saw him *-* alive on *19*Immediate cause of death: *Congenital heart -*DURATION *-*Due to: *-*Due to: *-*Other conditions *Sudden death*

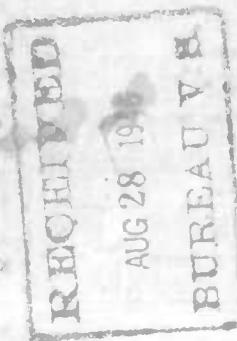
(Include pregnancy within 8 months of death)

Major findings of operations: *-* Date of op. *-*Autopsy results: *-*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: *-* Date of *-*Where did injury occur? *-* (City or town) *(County)* *(State)*Injured at home, farm, industry, public place (where?) *-*Means of injury *-* Injured at work? *-*23. SIGNATURE *R. D. Lillard* M. D. or other *-*Address *Prince Frederick and* Date signed *8/24*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 460

CERTIFICATE OF DEATH

07870

50

Reg. Dist. No.

1. PLACE OF DEATH:

County Cabell

City or town Colomons

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Cecelia F. Leathering

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

Jewell Leathering

7. Birth date of deceased (mo., day, yr.)

Mar. 27, 1856

6. (c) If alive, give age years

8. AGE: Years

90

Months

4

Days

25

If less than one day

- hrs. - min.

9. Birthplace

Whey - Cabell Co., Md

(Town, county, and state)

10. Usual occupation

Home

11. Industry or business

FATHER

12. Name

Thomas Groves

MOTHER

13. Birthplace

Md

14. Maiden name

Elizabeth Breden

15. Birthplace

Md

16. Informant

Mrs. Joe. Bafford

Address

Colomons, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug. 24, 1946

(month) (day) (year)

Cemetery or crematory

St. Paul's

Location

Whey, Md

18. Funeral director

A. A. Starkness & Son

Address

Mutual, Md

19. (Date rec'd by registrar)

1946

Date signed

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Cabell

City or town Colomons

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

20

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 22, 1946, at 1:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 15, 1946, to Aug. 21, 1946

and that I last saw her alive on Aug. 21, 1946

Immediate cause of death

Pulmonary Embolus.

DURATION

Due to

Atelectasis (generalized)

Due to

Ca of section

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

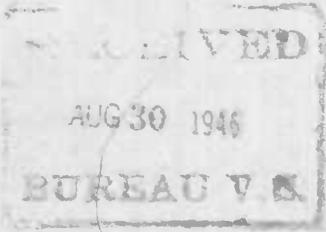
Injured at work?

23. SIGNATURE

M. D. or other

Address

Dr. J. L. Leathers Date signed 8/23/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

07871 58

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County CalvertCity or town Prince Frederick, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 weekHospital, institution, or street address where death occurred: Calvert County HospitalHow long in hospital or institution? 1 week

3. (a) FULL NAME

Zola K. Sinclair4. Sex F.5. Color or race W6. (a) Single, married, widowed, or divorced M.6. (b) Name of husband or wife Col. Burke N. Sinclair6. (c) If alive, give age 67 years7. Birth date of deceased (mo., day, yr.) Mar. 3, 18818. AGE: Years 65 Months 5 Days 13 It less than one day hrs. min.9. Birthplace Kentucky
(Town, county, and state)10. Usual occupation. Home

11. Industry or business

12. Name William E. Kilgore13. Birthplace Virginia14. Maiden name Mary Collier15. Birthplace Kentucky16. Informant Col. Burke N. SinclairAddress Parson, Md.17. Burial Date thereof Aug. 19, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Paul'sLocation Prince Frederick, Md.18. Funeral director A. G. Warkness & SonAddress Mt. Mutual, Md.19. 8-19 19 46 N.W. Ward
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 1800 cl. M. W.
(If rural, give LOCATION) 200

2.(a) If veteran, name war

3. (b) Social Security Number

23.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16, 1946 at 3:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 19.and that I last saw h. alive on 19.

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to

Hypertension, C.V.D.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

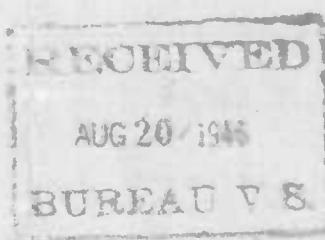
Means of injury

Injured at work?

23. SIGNATURE J. A. T. Collier

M. D. or other

Address Prince Frederick Date signed 8/17



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9

CERTIFICATE OF DEATH

07872

61

Reg. Dist. No. 51

1. PLACE OF DEATH: Calvert
 County: Prince Frederick MD
 City or town: Prince Frederick MD
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 months
 Hospital, Institution, or street address where death occurred: Calvert Co Hospital
 How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Calvert
 City or town: Prince Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war: _____

3. (a) FULL NAME Donald Lee Sipe

3. (b) Social Security Number

4. Sex: <u>M.</u>	5. Color or race: <u>W.</u>	6.(a) Single, married, widowed, or divorced: <u>S.</u>
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6.(b) Name of husband or wife: _____

7. Birth date of deceased (mo., day, yr.) Dec 7, 1945 6.(c) If alive, give age: _____ years

8. AGE: Years: <u>8</u>	Months: <u>11</u>	Days: <u></u>	If less than one day: <u></u>	hrs: <u></u>	min: <u></u>
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9. Birthplace: Prince Frederick, MD
 (Town, county, and state)

10. Usual occupation: _____

11. Industry or business: _____

MOTHER FATHER
 12. Name: Herbert C. Sipe

13. Birthplace: Charlottesville, Virginia

14. Maiden name: Anna Margarette

15. Birthplace: Prince Frederick

16. Informant: Mother (Anna Sipe)
 Address: Prince Frederick

17. Burial: Burial Date thereof: 8-19-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: St. Paul

Location: Prince Frederick, MD

18. Funeral director: R. A. Bookness Assoc.
 Address: Mutual, MD

19. (Date rec'd by registrar) 8-19-46 19 46 H. W. Edwards
 (Date signed) Aug 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18 19 46 at 9 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 18 19 46 to Aug 18 19 46 and that I last saw him alive on Aug 18 19 46

Immediate cause of death: Pneumonia, malnutrition

Due to: Whooping cough

Due to: _____

Other conditions: malnutrition

(Include pregnancy within 3 months of death)

Major findings or operations: _____ Date of op. _____

Autopsy results: _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: R. A. Bookness Assoc. M. D. or other _____

Address: Prince Frederick Date signed: Aug 19 1946

RECEIVED

AUG 21 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 400

07873

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH:

County..... Calvert
City or town..... St. Leonard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Taylor.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m.C.

6. (b) Name of husband or wife

Ella Taylor.6. (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.)

July 4, 1882.

8. AGE:

Years 64 Months

Days

If less than one day

hrs.

min.

9. Birthplace

md.
(Town, county, and state)

10. Usual occupation

Laborer.

11. Industry or business

Alston Taylor.

12. Name

Alston Taylor.

13. Birthplace

md.

14. Maiden name

Mary Meyers.

15. Birthplace

md.

16. Informant

Gladys Washington.

Address

St. Leonard.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 8-24-46

(month) (day) (year)

Cemetery or crematory

St. John's.

Location

Calvert.

18. Funeral director

P. E. Sewell.

Address

Prince Frederick, Md.

19. Date rec'd by registrar

Aug 24 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Calvert.City or town St. Leonard. (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 8-21-1946 21 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 20 1946, to Aug 21 1946and that I last saw h..... alive on Aug 21 1946

19

Immediate cause of death.....

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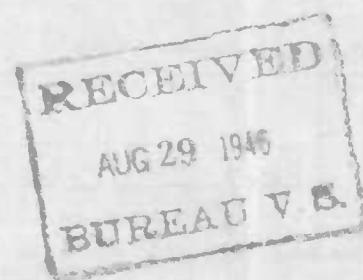
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Death

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 51

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County CalvertCity or town Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:

Calvert Co. HospitalLength of mother's stay in County 12 years
(How many years, or months, or days. SPECIFY WHICH)3. Name of child — none —5. Sex Male 6. Twin or triplet —

FATHER OF CHILD

8. Full name — Benjamin Tyler9. Color et 10. Age at time of this birth 58 yrs.11. Usual occupation — Farmer16. Other children born to mother (not including present child): (a) How many children of this mother are now living? — (b) How many other children were born alive but are now dead? — (c) How many other children were born dead? —17. Did child die before labor? no During labor? yes18. Pregnancy, complications of — none19. Labor: (a) Complications of — none (b) Induced? —20. (a) Was there an operation for delivery? no (Yes or No)(b) State all operations, if any —(c) Did child die before operation? —
During operation? —23. (a) Buried (b) Date thereof 8-6-16
(Burial, cremation or removal) (month) (day) (year)(c) Cemetery or crematory — Mt. Oliver24. (a) Funeral director P.E. Sewell
(b) Address Prince Frederick, MD

2. USUAL RESIDENCE OF MOTHER:

State MarylandCounty CalvertCity or town Apex
(If outside city or town limits, write RURAL and give nearest town)Street No. —
(If RURAL give LOCATION)4. Date of birth Aug. 5 1946 Hour 9 AM7. No. of weeks pregnancy 24 weeks

MOTHER OF CHILD

12. Full maiden name Widder Thomas13. Color et 14. Age at time of this birth 12 yrs.15. Usual occupation — School girl

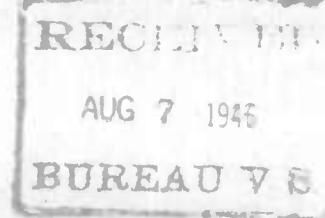
21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes — prematurity(b) Maternal causes — none

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature P. de Villars
(Specify if M. D., midwife, or other)Address Prince Frederick25. (a) Aug. 6 1946 (b) H. W. Ward
(Date rec'd by registrar) Local (Registrar)26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per



Evidence for change of age
of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

07875 #63

FILM No. 107 SEP 16 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County.....

Calvert and

City or town.....

St. Leonard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charity Wallace

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

7

8

X

6. (b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)

Nov - 1869.

6. (c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

hrs.

min.

77 76

9. Birthplace.....

MD

(Town, county, and state)

10. Usual occupation.....

Domestic.

11. Industry or business

FATHER

Patrick Wallace.

MOTHER

MD.

14. Maiden name.....

Sarah Blossey.

15. Birthplace.....

MD

16. Informant.....

Dona Hawe.

Address

St. Leonard, MD.

17. Burial.....

Date thereof.....

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Island Creek.

Location.....

Calvert.

P. E. Sewell.

18. Funeral director.....

Address

Prince Frederick.

19.

9-1

1946

2X-W. Wards

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

MD

County.....

Calvert

City or town.....

St. Leonard.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

8-29. 1946, at 4:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Cerebral hemorrhage

Due to.....

Due to..... Hypertension C. V. D

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

John Villareal 5 M. 1
Prince Frederick 8/31
M. D. or other
Address..... Date signed.....

